



European Monitoring Centre
for Drugs and Drug Addiction



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Drug treatment systems in the Western Balkans

Outcomes of a joint EMCDDA-UNODC survey of
drug treatment facilities



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* This designation is without prejudice to positions on status, and is in line with UNSCR 1244 and the ICJ Opinion on the Kosovo declaration of independence. It applies to all mentions of Kosovo in this publication.

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Introduction

Background

This report presents a complex picture of the achievements and challenges of drug treatment systems in the Western Balkans, a politically defined region comprising the Balkan states yet to become members of the European Union (EU): Albania, Bosnia and Herzegovina, Serbia and the territory of Kosovo.

The region has experienced considerable political and social change since the early 1990s as a result of the break-up of the Socialist Federal Republic of Yugoslavia. This period has been marked by a shift towards the independence of most former Yugoslav republics, which has entailed political reconstruction, armed conflicts, intraregional migration and the displacement of large populations through a process that is not yet fully consolidated. A transition of such scale, and the challenges that the region has experienced as a result, can generate structural conditions conducive to a high-risk environment in the context of illicit drug use. This is true in particular with regard to drug use disorders and related health and social consequences.

Furthermore, one of the most established international distribution routes for illicit drugs, the 'Balkan route', which links Afghanistan to the large markets of Russia and western Europe, passes through the Western Balkans. It is a particularly important route not only for the heroin trade but also for cocaine and cannabis (EMCDDA and Europol, 2016; UNODC, 2018a). As far as responses to the drug phenomenon are concerned, alignment with the EU has brought new challenges related to the transposition of the EU *acquis* into the countries' national legislation, especially in the area of justice and home affairs. However, it has also created new opportunities for cooperation and for discussions on approaches addressing illicit drug use, associated health and social harms, and responses. This report is an example of such collaboration, presenting the outcomes of joint work between the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and the Western Balkan states to obtain an updated overview of the countries' national drug treatment systems.

The EMCDDA works with EU Member States to develop a comprehensive drug monitoring framework. It monitors

developments in the EU drug situation through a variety of methods, including a set of key epidemiological indicators and data collection on the provision of, access to and the availability of drug treatment in EU Member States, as well as on drug markets and supply. Over the past decade, the EMCDDA has expanded and consolidated its cooperation with national drug authorities in candidate and potential candidate countries to the EU in the Western Balkan states — Albania, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Montenegro, Serbia and the territory of Kosovo. This collaboration aims to align the drug monitoring systems of these countries and Kosovo with the comprehensive EU drug monitoring framework. This has been possible owing to funding made available to the EMCDDA through the Community Assistance for Reconstruction, Development and Stabilisation programme and the Instrument for Pre-Accession Assistance (IPA), under which several consecutive projects have been carried out since 2008. The work to support the region in further consolidating their drug information systems and producing reliable data on the current drug situation is continuing under the EMCDDA IPA 6 project 'Stepwise integration of the IPA beneficiaries in the activities of the EMCDDA activities and the REITOX network', initiated in July 2017.

The UNODC collects, analyses and reports data on the extent of, patterns in and trends in drug use and its health consequences through the Annual Report Questionnaire (ARQ) (UNODC, 2018b). The data collected through the ARQ enable the monitoring of and biennial reporting to the Commission on Narcotic Drugs (CND) on the implementation by Member States of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. In addition, the UNODC supports the UN Member States in their efforts to set up, improve and maintain effective data collection systems on drug use and service planning, with a view to reducing drug demand. It does this through global, regional and national projects, such as the UNODC-WHO Programme on Drug Dependence Treatment and Care (UNODC, 2018c).

Since 2010, the UNODC in collaboration with the WHO has provided technical assistance to the region of South Eastern Europe in five countries — Albania, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Montenegro, and Serbia — in collaboration with the

relevant ministries. This initiative has been carried out through the Programme on Drug Dependence Treatment and Care (GLOK32). The project aims to promote policies that strike the right balance in terms of reducing drug supply and demand, and incorporate science-based drug prevention and dependence treatment.

The aims of the facility surveys in the Western Balkan region

The situation regarding the provision of treatment for drug use disorders within the Western Balkan region is variable. Past studies have indicated that, in general within the region, there is a combination of state programmes and services provided by non-governmental organisations (NGOs), frequently with the support of international donors and regional networks (EMCDDA, 2015). Specialist drug treatment services, both in- and outpatient, are largely linked to psychiatric hospitals, and, except in Serbia, little or no drug treatment is provided through general practice clinics. The availability of specialist drug treatment interventions is particularly limited in Albania and Kosovo, where there is a single, government-supported specialist drug treatment centre, supplemented by NGO services. However, the introduction or scaling up of opioid substitution treatment (OST) constitutes one of the most notable achievements documented in the Western Balkans in the past 10 years. In 2012, Kosovo introduced OST, with the financial support of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Founded in 2002, the Global Fund is a partnership between governments, civil society, the private sector and people affected by AIDS, tuberculosis and malaria. The Global Fund is the world's largest financier of AIDS, TB, and malaria prevention, treatment and care programs. In the Western Balkan region, it has been one of the main external funding sources for developing national capacities to deliver evidence-based services, such as voluntary counselling and testing, needle and syringe programmes, OST, and the promotion of treatment for hepatitis C infection for people who inject drugs. Since 2003, the Global Fund has signed 13 grant agreements in the Western Balkans and more than EUR 100 million has been committed to support the provision of HIV prevention services to vulnerable groups, including people who inject drugs. However, the Global Fund's financial support to harm reduction operations has been, or is about to be, discontinued in most countries in this region, and the prospects for sustaining current services and their quality remain unclear.

Data on treatment provision in the region remain patchy. The data that are available are not yet fully comparable and the coverage of national monitoring systems remains partial in most of the countries. Nonetheless, information about the characteristics, capacity, performance and quality of national treatment systems and specific parts thereof is required to plan treatment provision and commissioning, and to identify access barriers and support investment decisions. Regular standardised client monitoring and surveying of drug treatment facilities are therefore important to determine if key policy objectives are being met, that is, to answer questions such as 'Do people have adequate access to treatment?' 'What treatments are offered?' and 'Are these treatments evidence-based and cost-efficient?'

To support governments in the region to meet these policy information needs and to complement the available treatment-related data collected through standard monitoring systems, a pilot survey of treatment facilities providing services to individuals with substance-related problems was carried out by the EMCDDA with experts in Albania, Bosnia and Herzegovina, and Kosovo in 2017. The pilot survey relied on nationally adapted versions of the European Facility Survey Questionnaire (EFSQ) (EMCDDA, 2017a) and was supported financially by the EMCDDA IPA 5 project 'Preparation of the IPA beneficiaries for their participation in the European Monitoring Centre for Drugs and Drug Addiction' (EMCDDA, 2017b). In addition, the UNODC and WHO supported the government of Serbia in conducting a facility survey in Serbia, also in 2017, using the WHO-UNODC mapping tool, which is a drug treatment facility survey questionnaire that is, to a large extent, compatible with the EFSQ.

The main aim of these national facility surveys was to collect information from drug treatment providers across national addiction treatment systems on their characteristics, client utilisation, staffing, quality management and the availability of interventions, while accounting for their diversity.

This report provides a summary of the key findings from the drug treatment facility surveys carried out in 2017 in the Western Balkans, as well as conclusions and implications for practice and policy.

It should be noted that the comparability of the results between populations is limited because of the differences in design and methodology between the relevant studies (see Chapter 2). Therefore, data from each survey are presented in individual chapters. Each chapter comprises four main elements. At the beginning, some key information on the most recent data on the drug situation is presented, followed by a short overview of the

national treatment system in the country in question. The information presented in these overviews refers to data from 2015 or earlier, drawn from national reports and drug overviews produced by the governmental authorities and published on the EMCDDA website (EMCDDA, 2018a). The overviews also include tables concerning the networks of outpatient and inpatient treatment facilities. Data presented in these tables were produced by experts during a workshop on treatment system mapping in 2016 and refer to the data collection year 2015.

The third part addresses the main focus of this report and presents a summary of the key findings from the treatment

facility surveys carried out in 2017 in Albania, Bosnia and Herzegovina, and the territory of Kosovo, and in 2016-17 in Serbia. The data presented in this section relate to services and clients at the facilities during a pre-defined reference period from January 2016 to December 2016 in Albania, Bosnia and Herzegovina, and the territory of Kosovo and in Serbia.

The final section provides concluding remarks as well as considering possible implications for practice and policy at national level, based on reports produced by the experts using the findings from the treatment facility surveys and their knowledge of the situation.

Methods

To support the implementation of the facility surveys, the EMCDDA organised two technical workshops, in collaboration with the UNODC, under the framework of the IPA 5 project. The first took place in Lisbon in December 2016 and the second in Tirana in May 2017. Both workshops were attended by representatives of Albania, Bosnia and Herzegovina, Serbia, the territory of Kosovo and the UNODC. In addition, external experts from the Czech Republic were contracted to provide methodological support. During the workshops, the participants discussed sampling and data collection methods, as well as the adaptation of the questionnaires to address national characteristics and information needs.

Two different, but to a large extent compatible, survey questionnaires were used: the EFSQ in Albania, Bosnia and Herzegovina, and the territory of Kosovo, and the WHO-UNODC Substance use disorder treatment facility survey (UNODC and WHO, 2018) in Serbia. The WHO-UNODC survey was developed as part of the UNODC-WHO Programme on Drug Dependence Treatment and Care for the purpose of mapping the substance use disorder treatment services in a given country (UNODC, 2018d). The WHO-UNODC survey questionnaire consists of five sections: treatment facility contact details for survey correspondence; treatment facility contact details for the general public; description of the treatment facility and treatment offered; number of people treated; and treatment capacity (buildings and staff). The data provided in response to this questionnaire can be used for several purposes. The survey's aim is to collect information on the scope of treatment services provided, and consolidated data on the number of treatment clients, available human resources and the facilities' structural resources. The data may be used to map services in a country or region, to develop a register for the general public, for research (in consolidated form) or as a basis for treatment availability, accessibility and quality monitoring. The facility survey, together with the International Standards for the Treatment of Drug Use Disorders (UNODC and WHO, 2016), the Treatment Demand Indicator (TDI) and the UNODC Treatment Quality Assurance Tool, forms part of a basic suggested package for treatment planning and monitoring.

The EFSQ is a data collection instrument applicable in any country interested in surveying facilities that provide interventions to drug users. It consists of five sections: administrative characteristics (Section A); client utilisation (Section B); staffing and quality management (Section C); core interventions (Section D); and a glossary of terms used in the questionnaire (Section E). A manual on how to carry out a survey of drug treatment facilities using the EFSQ, as well as an electronic version of the EFSQ for a web-based survey

using the open source survey software LimeSurvey, can be found on the EMCDDA website (EMCDDA, 2017a). For the facility surveys carried out in Albania, Bosnia and Herzegovina, and the territory of Kosovo with the EFSQ, three additional questions on the budgets (total budget, funding sources and share of the total budget by each funding source) of the units (facilities) were added. The EFSQ was translated into the national languages by the EMCDDA and the national versions were checked and pre-tested. This step is described in the relevant chapters of this report.

The sampling unit of the survey is a service *unit*. A unit is defined as a separate, stand-alone organisational entity (a medical centre, a department, a programme, etc.) that has its own defined objectives, procedures, rules and scope of services and interventions, its own target group(s), and a team and manager (team leader). How exactly a unit is defined depends on the parent organisation or the responsible manager and its organisational structure, but each unit should be reported on as one of the main provider types defined by the EMCDDA in the EFSQ (Table 1).

If the parent organisation or facility operates several units that meet the criteria for the target unit, each distinct unit should complete the survey. If the unit provides multiple types of services, the type of unit is selected in accordance with the services that the unit primarily provides (typically determined by number of clients).

Taking into account the regional similarities of treatment systems in the Western Balkans, it was decided that the coding of types of services into the EFSQ standardised categories would be harmonised as shown in Table 1.

The sampling frame, that is, the list of drug service providers to be addressed, was prepared by experts nominated by their governments to work with the EMCDDA and the UNODC on this project, in collaboration with the relevant governmental authorities and ministries. The list was to consist of all institutions potentially providing services to individuals with substance-related problems. Participation in the survey was contingent on a positive response to the following question, which was the first question in the survey and acted as a filter for participation: 'Do you provide addiction treatment, counselling or other services to clients/patients with addiction problems (at least one person in previous 12 months with problems with use of tobacco and/or alcohol and/or illicit drugs and/or gambling)?' If the answer to this question was negative, the respondent was redirected to the end of the questionnaire without being asked to fill out the survey. If the answer was positive,

the respondent was invited to continue with the survey. If the respondent represented more than one unit providing services to drug users, they were asked to complete the questionnaire for each unit separately (Table 2).

In Bosnia and Herzegovina, data were collected in two separate surveys, one for the Federation of Bosnia and Herzegovina (FBiH) and one for the Republic of Srpska (RS). The results of both are reported for Bosnia and Herzegovina as a whole in this report.

TABLE 1
Types of facilities included in the various EFSQ categories

Typology of treatment facilities used in the EMCDDA data collection system and the EFSQ	Types of facilities in the Western Balkans corresponding to the EMCDDA-EFSQ categories
Outpatient units	
Specialised outpatient treatment unit	OST centres Outpatient addiction treatment centres in psychiatric hospitals/clinics/departments Any other specialised outpatient centre for substance users
Low-threshold unit	Typically drop-in centres
General mental healthcare unit	Community mental health centres Outpatient psychiatric centres in psychiatric hospitals/clinics/departments
General (primary) healthcare unit	Primary health centres, family doctors
Other outpatient unit (specify)	Social outpatient counselling units, for example
Inpatient units	
Hospital-based residential treatment unit	<ul style="list-style-type: none"> Addiction treatment departments Psychiatric wards in general or specialised hospitals psychiatric hospitals
Non-hospital-based residential treatment unit	<ul style="list-style-type: none"> Any non-medical inpatient facility other than a therapeutic community
Therapeutic community unit	<ul style="list-style-type: none"> Therapeutic communities (usually run by an NGO or religious organisation)
Other inpatient unit (specify)	<ul style="list-style-type: none"> Any other inpatient facility
Specialised social reintegration /aftercare unit	<ul style="list-style-type: none"> Outpatient or inpatient facilities for social reintegration and support after treatment
Other (specify)	<ul style="list-style-type: none"> Any other facility not belonging to the categories above

TABLE 2
Overview of the design and data collection process of the facility surveys in the Western Balkans

Type of programme	Albania	Bosnia and Herzegovina	Kosovo	Serbia
Instrument	EFSQ	EFSQ	EFSQ	WHO-UNODC facility survey questionnaire
Number of facilities addressed	41	71	6	53
Number of units included in the sample	10	55	5	39
Type of institutions addressed	Public, private, NGOs	Public, NGOs	Public, NGOs	Public, private, NGOs
Time of data collection	February to May 2017	March to May 2017	February to May 2017	October to December 2017
Reference period for the total number of clients in treatment (by primary substance and for OST clients)	January to December 2016	January to December 2016	January to December 2016	January to December 2016
Data collection mode	Electronic version of the questionnaire sent by email or post	Electronic or paper-based versions of the questionnaire sent by email or post	Electronic version of the questionnaire sent by email	Online questionnaire and questionnaire in Microsoft Word document sent by email or by post

Albania

KEY DATA

Total population: in 2017, Albania had 2.9 million inhabitants.

High-risk drug use: in 2014/15, estimates of the number of high-risk drug users (primary opioid users) in Albania ranged from 3 469 to 8 737. It is estimated that 6 out of 10 high-risk drug users use drugs by injection, with a large proportion of them injecting daily (EMCDDA, 2017c).

Treatment population: approximately 1 130 individuals received drug treatment in Albania in 2015 (EMCDDA, 2017c).

Overview of the treatment system in Albania

Treatment availability remains limited in Albania, and the main focus is on OST. The public sector and NGOs are the main stakeholders involved in drug treatment and harm reduction service provision. There is only one public centre that treats high-risk drug users, the Addictology and Clinical Toxicology Service of Tirana University Hospital Centre 'Mother Theresa' (TUHC), formerly known as the Clinical Toxicology Service. The TUHC, which has 20 beds, covers the whole country, deals mainly with detoxification and overdose treatment, and serves as both an inpatient and outpatient unit. Other psychiatric services will not provide treatment to high-risk drug users, unless they present with psychiatric comorbidities. A second specialised inpatient centre is operated by the NGO Emanuel, a therapeutic community with around 20 beds.

Methadone maintenance treatment was first made available in 2005 by the NGO Aksion Plus, funded by the Soros Foundation. About 915 clients received free-of-charge methadone treatment between 2005 and 2015 (an average of 90 clients per year). This included people in custodial settings, as Aksion Plus offers methadone maintenance treatment to prisoners who need it. Today, Aksion Plus operates six units in Tirana and five other districts. Currently, methadone is the only OST medication available in Albania.

Data reported to the EMCDDA indicate that, of approximately 1 130 drug treatment clients in Albania in 2015, three-quarters were treated in outpatient settings (Figure 1). It should be noted that there is no common drug treatment data collection system in Albania; treatment facilities report their clients separately, possibly resulting in double-counting of some clients.

The data available from the TUHC indicate that the numbers of people entering drug treatment in the facility annually have fallen since 2008, when 856 clients entered treatment. The TUHC reports that 473 clients entered drug treatment in 2015. The number of clients who were entering treatment for the first time also varied considerably between 2008 and 2015, with a low of 41 reported in 2008 and a high of 218 reported in 2009. In 2015, 150 new clients entered treatment.

Regarding the type of drug used by clients entering treatment, a decline in the proportion of treatment demands relating to opioid use was recorded between 2006 and 2012 (from 71 % to 29 %). However, this changed in 2013, when the proportion of opioid-related treatment demands increased, and by 2015 around 40 % of clients were entering treatment primarily because of opioid use. Demand for treatment related to cocaine use has increased in recent years too. In 2015, cocaine was the second most prevalent primary substance, accounting for one-third of all treatment entries. The proportion of clients seeking treatment for cannabis use has also gradually increased since 2006, with approximately one-quarter of treatment entries linked to cannabis use in 2015. The available data also indicate a steady increase in polydrug use among treatment clients.

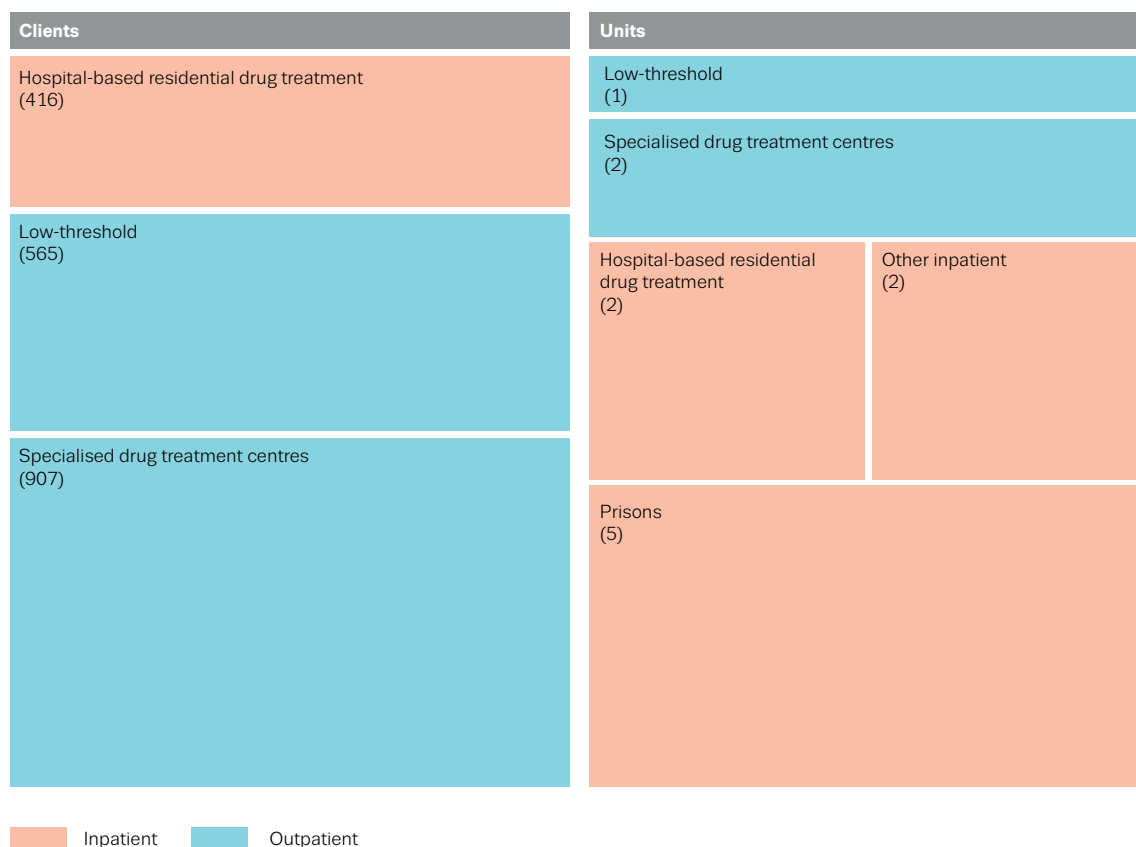
Findings from the 2017 treatment facility survey using the EFSQ in Albania

Sampling

All district, regional and tertiary general hospitals, as well as all major private hospitals in Tirana and all NGOs working in the drugs field in Albania, were contacted. In total, the invitation to participate was sent to 24 general district hospitals, 11 general regional hospitals, one tertiary hospital, two major private hospitals in Tirana

FIGURE 1

Total number of clients receiving treatment and units providing treatment by outpatient and inpatient unit type in Albania in 2015



NB: 'Other inpatient' units are one acute drug intoxication treatment unit and one dual diagnosis inpatient treatment unit. No data are available on the total number of clients for prisons and 'other inpatient' units.

and three NGOs offering various services to people with substance-related addictions, including alcohol. Preliminary information indicated that primary healthcare centres and polyclinics in Albania do not provide services to individuals with substance-related problems, so these were not included in the sampling frame.

The inclusion criterion for the survey was a positive response to the question 'Do you provide addiction treatment, counselling or other services to clients/patients with addiction problems (at least one person in previous 12 months with problems with use of tobacco and/or alcohol and/or illicit drugs and/or gambling)?' A translated version of the EFSQ was sent in hard copy or by email to all 41 institutions in the sampling frame. One private hospital, and all the district hospitals (24) and regional hospitals (11) responded 'no' to the screening question and were therefore excluded from the survey. The other private

hospital failed to provide the data required and was also excluded. The final sample of facilities therefore comprised the only tertiary hospital in the capital, Tirana, and three NGOs working with people with addictions. The tertiary hospital in Tirana had three units suitable to complete the questionnaire, but one unit did not provide data. One NGO had only one unit and another had six units. The third NGO had two units: one was still operating, but the other had ceased providing addiction services and answered 'no' to the screening question. In total, 10 units from 4 parent organisations completed the EFSQ in Albania.

There were no particular legal or ethical issues involved. The survey was carried out with the approval of the Ministry of Health and all the institutions consented to participate in the survey. Client data were anonymous and provided in aggregated form.

In summary, the Albanian translated version of the EFSQ was filled out by seven low-threshold units (six of them providing OST), two hospital-based residential treatment units and one specialised social reintegration/aftercare unit. Between January and December 2016, these units provided treatment to 2 585 clients, of whom 1 970 were treated for a substance use-related problem.

Results

Type of facilities, geographical distribution and funding

The findings from this survey show that treatment services are concentrated primarily in Tirana, the capital of Albania (Table 3). In six prefectures of Albania (representing approximately 30 % of the country's total population), public institutions or NGOs offering treatment services are not available.

Overall, 8 of the 10 units offering services to individuals with substance-related problems can be categorised as NGOs, whereas the two remaining hospital-based inpatient units were public institutions funded by the government. The majority (80 %) of entities offering services to individuals with substance-related problems reported that they were funded either entirely (20 %) or partly (60 %) from the state budget. Six units were financed jointly by the state and the Global Fund, and two others had other sources of funding. Low-threshold units reported serious financial difficulties in the context of uncertain future

funding from the Global Fund in Albania and economic constraints affecting other donor organisations.

Target population and client characteristics

The 10 surveyed units provided treatment to 2 585 clients in 2016. Two-thirds of these were served by hospital-based residential units, 30 % were served by low-threshold units and approximately 8 % were served by the specialised social reintegration unit. Between 80 % and 90 % of clients received treatment in Tirana.

The majority of clients (1 970, 76 %) were treated for substance-related problems, including alcohol. Heroin was the primary problem drug in 64 % of cases, followed by cannabis (13 %), cocaine (11 %), and alcohol (9 %) (Figure 2).

FIGURE 2
Proportion (%) of clients of surveyed facilities by primary substance in Albania in 2016 (EFSQ, 2017)

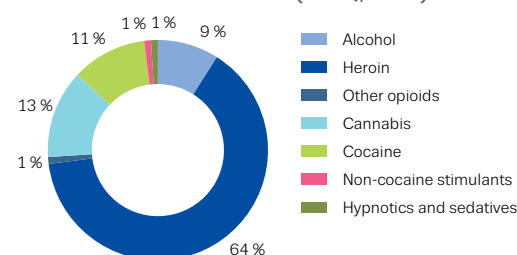


TABLE 3

Number of units by region and unit type in Albania in the 2017 EFSQ facility survey

Region (level 2)	Region (level 3)	Low-threshold	Outpatient specialised	Outpatient non-specialised	Hospital-based inpatient	Other inpatient	Specialised reintegration/aftercare	Total
Northern region	Diber	0	0	0	0	0	0	0
	Durres	1	0	0	0	0	0	1
	Kukes	0	0	0	0	0	0	0
	Lezhe	0	0	0	0	0	0	0
	Shkoder	1	0	0	0	0	0	1
Central region	Tirana	2	0	0	2	0	1	5
	Elbasan	1	0	0	0	0	0	1
Southern region	Berat	0	0	0	0	0	0	0
	Fier	0	0	0	0	0	0	0
	Gjirokaster	0	0	0	0	0	0	0
	Korce	1	0	0	0	0	0	1
	Vlore	1	0	0	0	0	0	1
Total		7	0	0	2	0	1	10

Staffing

There was a full-time equivalent (FTE) of 72.5 staff employed across all 10 surveyed units. A breakdown by profession types reveals that the main professions represented in the survey are addiction or psychiatric nurses (14.5 FTE), medical doctors specialised in addiction medicine or addiction psychiatry (12 FTE), general nurses (11 FTE) and psychologists (9 FTE).

The staffing of the units tends to reflect their nature and operating field. Low-threshold units employ mostly psychologists and social workers, while hospital-based units employ mostly doctors specialised in addiction treatment and addiction psychiatry, and both specialist addiction and general nurses.

Provision of services and quality assurance

In response to questions about the range of services provided, all surveyed facilities in Albania reported that they 'frequently' or 'always' provided counselling and psychotherapy interventions and/or services. In addition, all units indicated that they 'frequently' or 'always' provided case-management services, and a large majority (between 80 % and 90 %) reported that they 'frequently' or 'always' provided brief psychosocial interventions, individual, group and family counselling, and internet-based treatment.

OST was available in six out of the twelve level 3 regions in the country and was provided by low-threshold units that also dispensed the medication. In total, 719 clients had received OST in the previous year, with the unit in Tirana serving almost half of OST clients (345, 48 %). Eight out of ten units included in the survey offered pharmacologically assisted management of withdrawal, that is, detoxification (all six low-threshold units and both of the hospital-based residential treatment units).

All the low-threshold units and the specialised social reintegration unit provided services to prison inmates with substance-use problems. During 2016, a total of 900 prisoners received such services, with an overwhelming proportion being offered to inmates in Tirana's prisons. However, nearly 90 % those receiving services did so from one unit alone: the specialised social reintegration unit.

In addition, 80 % of all provider units in Albania reported that they 'frequently' or 'always' offered services to children and adolescents, clients with mental health and substance disorders, sex workers, and ethnic and minority groups. However, a lack of services for women and homeless drug users was reported in the survey.

With regard to infectious disease testing and other related services, only one unit reported that they 'always' or 'frequently' offered on-site HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV) diagnostic testing; and other services related to infectious disease care were offered even less frequently. On-site HBV vaccination, on-site HCV infection treatment and on-site antiretroviral treatment for HIV/AIDS were, in general, either rarely offered or not offered, despite the perceived need for these services. The survey indicated that these services were never offered in hospital settings because there was not a perceived need for them.

Various harm reduction services were offered by the units included in the survey. The harm reduction service most often reported (by 80 % of all units) as provided 'frequently' or 'always' was the distribution of information material on safer injecting and drug overdose prevention. This was followed by street outreach work, the distribution of syringes and other drug-injecting equipment, and the distribution of condoms (offered by 70 % of all units). The distribution of information material targeted at recreational drug users and partygoers was reported as being 'frequently' or 'always' provided by only two units, with seven others reporting that they either 'rarely' or 'sometimes' provided these services, and one unit reporting that this service was not needed. Social reintegration services, such as employment support or vocational training, were offered by fewer units on a regular basis. Six units reported offering these services 'frequently', but none as a standard service (i.e. 'always'). Six units sometimes provided housing support, while the remaining four did so 'rarely' or 'never'.

As social reintegration services for drug users in treatment are more commonly taken care of by external health and social institutions, most units had established collaborations with at least one other health or social institution. All units, except for one hospital-based unit, collaborated with other health institutions (90 % of units). Similarly, except for one low-threshold unit, all units collaborated with social services, and all but one hospital-based residential unit collaborated with other specialised drug and alcohol treatment services. Eight of the ten units (all except for one hospital-based unit and one low-threshold unit) collaborated with prisons and probation services, and the same proportion collaborated with unemployment services.

All units reported having state-recognised accreditation, but only one could provide proof or suggest a basis for such recognition. Almost all units had internal and external quality assurance mechanisms in place, although the extent to which they were applied was unclear.

Conclusions and implications

The findings from the 2017 EFSQ survey in Albania indicate that access to treatment is constrained by the lack of geographical coverage of the treatment services available in the country. The estimated number of high-risk drug users in Albania, compared with the number of those currently receiving treatment, suggests that approximately 75 % of high-risk drug users are not reached by treatment services. In addition, the survey findings indicate that some key groups are currently inadequately served, including homeless people and women. Harm reduction services and counselling or psychotherapy interventions seem to be widely available from existing service providers, but testing for infectious diseases is rarely available, as are social reintegration services.

The geographical disparity in the availability of treatment and harm reduction services highlights the need to support the implementation of new services outside the capital. This is necessary to improve access to drug services in other areas of Albania, to reduce the level of unmet needs

and to reduce the current burden on providers in the capital city. In this regard, it may be useful to consider the possibility of involving primary healthcare centres in the provision of drug services. Another important implication of these findings, and one requiring immediate attention, concerns the underfunding of NGOs that have been largely dependent on Global Fund financing in providing these services.

Finally, internal and external quality assurance mechanisms for service providers are crucial to improving the quality of care, yet the findings of the survey suggest that these may not be consistently applied. It is suggested that state accreditation processes be improved in order to establish and ensure compliance with quality standards for care provision, staffing and infrastructure. In addition, with regard to improving the quality of care in the Albanian treatment system, further studies are needed to identify barriers to accessing treatment. A better understanding of why high-risk drug users are not accessing treatment, and of client satisfaction with the current services, could be an important part of the evaluation of the treatment system.

Bosnia and Herzegovina

KEY DATA

Total population: in 2015, Bosnia and Herzegovina had 3.8 million inhabitants.

High-risk drug use: in 2009, the estimated number of people who inject drugs was 889 (95 % CI: 703-1075) in Sarajevo, 534 (95 % CI: 354-717) in Banja Luka and 852 (95 % CI: 809-895) in Zenica. These results were extrapolated to entity and state levels to give an estimated population of people who inject drugs in the FBiH in 2009 of 4 900; for the whole of Bosnia and Herzegovina, this would amount to 7 500 people (EMCCDA, 2018b).

Treatment population: in 2015, 2 115 treatment clients were registered in Bosnia and Herzegovina, of whom 1 310 received OST (EMCCDA, 2018b).

hospitals, or in psychiatric departments in general hospitals in smaller towns and in the Brčko District. There are five outpatient specialised drug treatment centres, which provide OST in Mostar, Tuzla and Zenica, Banja Luka, and Sarajevo, the largest urban areas in the country. OST is not available in the Brčko District or in prisons in the RS. Between 2006 and 2016, OST was funded by the Global Fund. To prepare for the withdrawal of the Global Fund from Bosnia and Herzegovina, a transition plan was drawn up by the national authorities. The tertiary level covers rehabilitation and social reintegration programmes, mainly implemented in therapeutic communities (mostly set up by NGOs).

Access to treatment is available and free of charge for those with health insurance. People who do not have health insurance have to pay for treatment in accordance with the price list for medical services.

Harm reduction services (e.g. the distribution of syringes and other drug-injecting equipment, overdose prevention leaflets, etc.) are offered through networks of outreach workers and 10 drop-in centres. Annually, around 3 100 injecting drug users receive support through these networks.

According to data from the Institutes for Public Health of the FBiH and the RS, 2 115 treatment clients were registered in Bosnia and Herzegovina in 2015, and there has been a slight increase in the number of clients treated in recent years. The available data indicate that the majority of treated clients use heroin or other opioids. More than 60 % of clients treated in the country received OST. In 2015, a total of 1 310 people were receiving OST, with methadone being the most prescribed maintenance treatment. The available data indicate an overall increase in the number of OST clients since 2011.

Overview of the treatment system in Bosnia and Herzegovina

Bosnia and Herzegovina has a state level government and comprises two autonomous entities, the Republic of Srpska (RS) and the Federation of Bosnia and Herzegovina (FBiH), with a third region, the Brčko District, under local government. Public health issues are the responsibility of the two entities and of the District, and the provision of drug-related treatment is under their oversight. In the RS, the Ministry of Health and Social Welfare is the responsible institution, while in the FBiH responsibility is shared between the federal ministry and the cantons. At state level, the Ministry of Civil Affairs is in charge of the overall coordination of public health.

The health system in Bosnia and Herzegovina (in the two entities and the Brčko District) is divided into primary, secondary and tertiary levels. Treatment of drug users (counselling, detoxification and OST) is available through inpatient and outpatient facilities, but most provision is through outpatient facilities (Figure 3). The primary level includes family medicine, some specialised services, and community mental health centres where counselling services, early detection, and treatment of mental disorders are provided. The secondary level includes outpatient and inpatient programmes for counselling, detoxification and OST in specialised centres, in psychiatric clinics or

Findings from the 2017 treatment facility survey using the EFSQ in Bosnia and Herzegovina

Sampling

In the RS (and the Brčko District), the translated version of the EFSQ was first piloted in three mental health centres to test for inconsistencies. The Ministry of Health and

FIGURE 3

Total number of clients receiving treatment and units providing treatment by outpatient and inpatient unit type in Bosnia and Herzegovina in 2015 or the most recent year



NB: no data are available on the total number of clients in low-threshold units.

Social Welfare of the RS provided the list of institutions to be surveyed. The inclusion criterion for participation in the survey was the generic criterion used across all countries: a positive response to the question 'Do you provide addiction treatment, counselling or other services to clients/patients with addiction problems (at least one person in previous 12 months with problems with use of tobacco and/or alcohol and/or illicit drugs and/or gambling)?' The translated version of the EFSQ was sent to 41 facilities by email, 32 of which met the inclusion criterion and filled out the EFSQ.

For the FBiH, the sampling procedure was similar. The inclusion criterion was all facilities in the Federation of Bosnia and Herzegovina that had treated at least one client/patient with an addiction-related problem in the period between January and December 2016. The list of facilities selected for the study was completed at the

beginning of March 2017. The following sources were used to create the list of institutions to be invited to take part in the survey: the national report on the drug situation in Bosnia and Herzegovina from 2014; data from the treatment system mapping exercise carried out during the annual TDI expert meeting in Lisbon in 2016 (see Chapter 2); data from the Federal Public Health Institute; and data from the Department of Health in the Ministry of Civil Affairs of Bosnia and Herzegovina. Some facilities were removed from the list because of a closure or a shift in the services provided. Facilities known to have opened recently were added to the list. The pilot study in the FBiH was performed internally at the Public Institute for Addiction Disorders of the Canton of Sarajevo, and externally by one therapeutic community in the Canton of Sarajevo. All the facilities were contacted initially by phone and were subsequently sent an email with the translated version of the EFSQ, as well as a letter from the Federal

Public Health Institute explaining the purpose and process of the survey. The translated version of the EFSQ was sent to 30 facilities by email, with 23 of them taking part in the survey.

There were no particular legal or ethical issues involved in either the RS or the FBiH. The survey was carried out with the approval of the health ministries and all the institutions consented to participate in it. Client data were anonymous and provided in aggregated form.

A total of 55 facilities took part in the survey using the EFSQ in Bosnia and Herzegovina.

Results

Type of facilities, geographical distribution and funding

The Bosnian version of the EFSQ was filled out by 55 facilities, 38 of which were outpatient facilities and 17 of which were inpatient facilities. Of the former, non-specialised outpatient units were predominant in the RS, there being only one specialised outpatient treatment unit. Conversely, in the FBiH, specialised outpatient treatment units were more common than non-specialised outpatient units. Hospital-based residential treatment units and therapeutic communities were available in both the RS and the FBiH. No low-threshold units took part in the survey (Table 4).

In the FBiH, there are two specialised centres, in Sarajevo and Zenica, as well as psychiatric wards for the treatment of drug users in Mostar and Tuzla. Overall, the geographical distribution of drug treatment services is concentrated

in the big cities and there is a lack of services in south-western regions, as well as in the Goražde area. In the RS, outpatient services are predominantly provided by generic mental health centres, with an overall lack of specialised outpatient institutions for the treatment of substance-related problems. The eastern part of the RS has no inpatient centres, and shows an uneven territorial distribution of OST centres, with most of them concentrated in the western part of the RS.

The main source of funding, as reported by most facilities in Bosnia and Herzegovina, is from the government, through the state budget, municipal budgets or health insurance funds. Twenty-nine institutions indicated that they were funded by the state budget (one unit did not respond to this question), and 21 institutions (mental health centres) indicated that they were funded by municipal budgets. Six units providing OST were receiving funding from the Global Fund, while 12 units reported additional sources of funding (from therapeutic communities and associations). The NGO Viktorija and the therapeutic community Izvor are funded by grants and projects.

Target population and client characteristics

For the whole of Bosnia and Herzegovina, results from the facility survey using the EFSQ show that the majority of clients received treatment through outpatient services. A total of 2 190 individuals received treatment through outpatient specialised services, and 1 726 clients received treatment in non-specialised general mental healthcare centres during the 12 months prior to the facility survey (Figure 4). In addition, 1 711 clients received treatment in hospital-based inpatient units, 444 clients received treatment in aftercare/social reintegration units, and 131 clients received treatment in therapeutic communities.

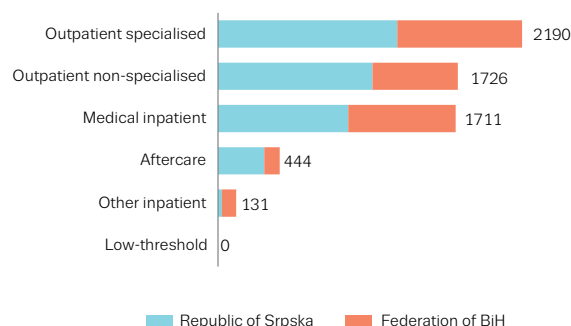
TABLE 4

Number of units by region and unit type in Bosnia and Herzegovina in the 2017 EFSQ facility survey

Region	Low-threshold	Outpatient specialised	Outpatient non-specialised	Hospital-based inpatient	Therapeutic community unit	Other inpatient	Specialised reintegration/aftercare	Total
Republic of Srpska	0	1	21	6	1	0	1	30
Brčko District	0	0	1	1	0	0	0	2
Federation of Bosnia and Herzegovina	0	10	5	3	3	0	2	23
Total	0	11	27	10	4	0	3	55

FIGURE 4

Total number of clients by unit type in Bosnia and Herzegovina in 2016 (EFSQ, 2017)



One difference stands out between the two entities: in the RS there were far more clients with alcohol-related problems (68 %) than with illicit drug-related problems (18 %), while in the FBiH the majority of clients reported illicit drug-related problems (73 %), followed by alcohol-related problems (13 %). This difference may be explained by the nature of the facilities providing services in each entity: non-specialised outpatient facilities in the RS address broader substance-related problems, including alcohol, while, in the FBiH, specialised drug treatment centres focus primarily on illicit drugs.

Among those receiving treatment because of illicit drug problems in Bosnia and Herzegovina, heroin was the primary drug (31 %), followed by cannabis (7 %), other opioids (5.7 %) and stimulants (2.4 %) (Figure 6).

Overall, in Bosnia and Herzegovina, 45 % of clients received treatment for alcohol-related problems and 41 % for illicit drug-related problems. Smaller proportions received treatment for the misuse of pharmaceuticals (4.6 %) and behavioural addictions related to gambling (2 %) (Figure 5).

Staffing

In the whole of Bosnia and Herzegovina, there was a full-time equivalent (FTE) of 965.1 staff employed across all surveyed units. A breakdown by profession types (Figure 7)

FIGURE 5

Proportion (%) of clients by primary problem substance or behaviour among surveyed facilities in Bosnia and Herzegovina in 2016 (EFSQ, 2017)

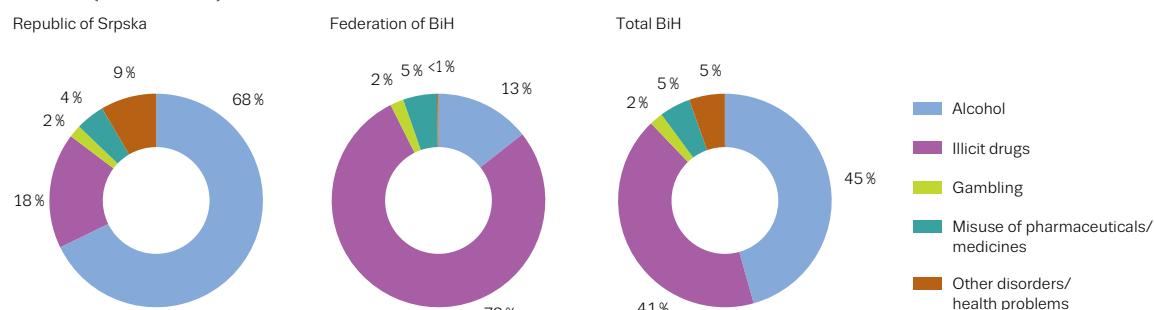


FIGURE 6

Proportion (%) of clients by primary substance among surveyed facilities in Bosnia and Herzegovina in 2016 (EFSQ, 2017)

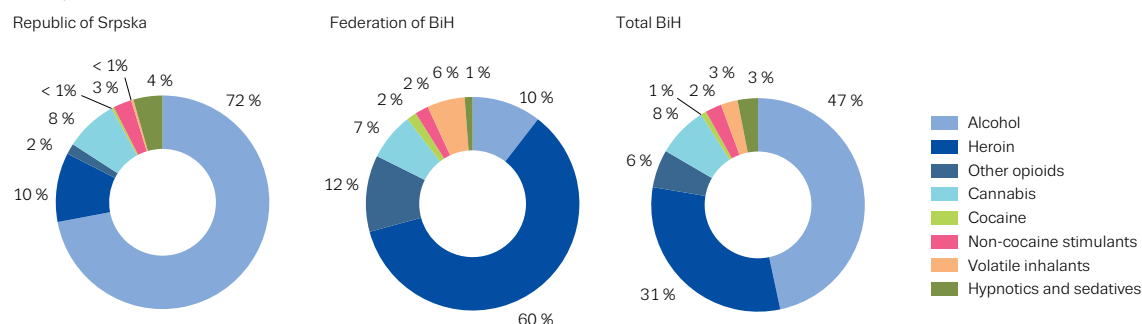


FIGURE 7

Staffing (FTE) by professional category in Bosnia and Herzegovina in 2016 (EFSQ, 2017)

reveals that the main professions represented in the survey are general nurses (301.5 FTE), administrative staff (195 FTE), psychologists (98.2 FTE) and general psychiatrists (84 FTE). However, large differences exist between the two entities. In the RS, the medical professionals (medical doctors and nurses) employed in treatment facilities are not specialised in addiction, although it can be assumed that experience is gained from working in the field for numerous years. The opposite is observed in the FBiH, where medical professionals specialised in addiction are employed across the surveyed facilities. Again, differences between the two entities may be explained by the lack of specialised services in addiction and substance-related problems in the RS, which may result in little uptake of addiction studies by medical professionals.

Provision of services and quality assurance

Results on the range of services provided across the surveyed facilities in Bosnia and Herzegovina show that their primary focus is on psychosocial and therapeutic care of individuals with substance-related problems, and OST provision. Between 50 % and 70 % of the facilities reported that they 'frequently' or 'always' provide individual counselling or brief interventions and, to a lesser extent, family counselling (30 %). Psychotherapeutic and socio-therapeutic activities are mostly carried out in

specialised institutions for treating addiction, while mental health centres provide primarily brief interventions and case management. On the other hand, harm reduction interventions (e.g. syringe exchange, materials for overdose prevention), testing for and treatment of infectious diseases, and social reintegration services are for the most part either rarely provided or not available. The facility that reported the availability of the most harm reduction activities was the NGO Viktorija.

Less than 5 % of facilities reported that they frequently provide on-site HCV testing and approximately 6 % reported frequent on-site HBV testing. Frequent testing for an HIV infection was reported by approximately 2 %. The only institution offering HCV treatment to drug users was the University Clinical Centre of the Republic of Srpska. In the FBiH, none of the units answered 'frequently' or 'always' in regard to testing for or treatment of infectious diseases. This is because most units refer patients to other clinics or departments of primary healthcare centres for testing for infectious diseases.

OST provision in the RS takes place in three mental health centres (Doboj, Trebinje and Sokolac) and in one specialised psychiatric outpatient service at General Hospital Bijeljina. The OST programme in Banja Luka works as a separate unit. There is currently only one centre for detoxification (the Department of Addiction at the Psychiatric Clinic, Banja Luka). In the FBiH, the Sarajevo Canton has adopted a centralised approach to OST, whereby it is provided only at the Institute for Alcoholism and Substance Abuse of the Canton of Sarajevo. In contrast, a decentralised approach is taken in Zenica, where the Institute for Addictions of Zenica Canton provides support for OST dispensing units located in outpatient mental health centres in smaller cities (Breza, Maglaj, Doboj Jug, Kakanj, Tešanj and Visoko). A similar principle is applied in Una-Sana Canton, where the OST units operate as part of outpatient mental health centres or primary healthcare centres. In the FBiH, pharmacologically assisted detoxification is available in Sarajevo, Zenica, Tuzla and Mostar.

The results from the facility survey in Bosnia and Herzegovina revealed that 1 675 individuals were prescribed OST in 2016, through 22 units. Ten specialised outpatient treatment centres prescribed OST to 1 163 clients; nine mental healthcare centres prescribed it to 356 clients; and three hospital-based residential treatment units to 156 clients. All units provide prescriptions for the medications and all but one also dispense the medication to the patient.

Regarding quality assurance mechanisms, 14 units reported that they possessed a certified state accreditation,

11 in the RS and three in the FBiH. In the RS, nine mental health centres, one therapeutic community, and one department of addiction at the Psychiatric Clinic held certified state accreditation. In the FBiH, two mental health centres operating within primary healthcare centres (Dom Zdravlja) and one NGO counselling centre stated that they had state agency accreditation (Accreditation Agency for Healthcare Standards). The majority of surveyed facilities in Bosnia and Herzegovina reported having internal quality assurance mechanisms in place. Over 70 % of facilities reported possessing manuals of procedures, carrying out regular team meetings, providing continuous learning and knowledge transfer activities for staff, and collecting and documenting client satisfaction feedback.

Conclusions and implications

These results are based on the 55 units that responded to the 2017 EFSQ survey in Bosnia and Herzegovina.

Drug treatment facilities are unevenly distributed geographically, with the majority of facilities located in the biggest cities (Banja Luka and Sarajevo), leaving the eastern part of the Republic of Srpska and two cantons of the FBiH (Canton 10 and West Herzegovina) without access to local treatment. Currently, OST is provided in a few prisons in the FBiH. While the current provision in these prisons should be commended, the units involved (as well as other relevant units and institutions) could be encouraged to expand the provision of OST and harm reduction interventions to other prisons in the country.

Clients in treatment for alcohol-related problems are more prevalent in the RS than in the FBiH. In the FBiH, more clients are in treatment for drug use, although the number of patients treated for drug use in the RS is increasing. Among patients treated for drug use, heroin is the main problem substance, followed by cannabis and other opioids. In the FBiH, the majority of treatment centres provide OST, while only a limited number of beds or outpatient treatment programmes for alcohol addiction were observed. This may have led to the underestimation of the number of people with alcohol problems in the treatment population, which could explain the difference between the two entities.

Several staffing issues (shortages, burnout, lack of specialisation) and stigma towards drug users and professionals working with them were reported. Efforts at governmental level could be considered to raise awareness about addiction among the general population and to offer more training to staff working in specialised addiction services or treatment centres.

Since September 2016, the Global Fund has stopped its financing activities in Bosnia and Herzegovina. The funding for various programmes implemented over the last 10 years is now to be ensured by the government, as stipulated in the Transition Plan for the Continuation of HIV and Aids Prevention, Treatment and Care in Bosnia and Herzegovina 2015-2017. Finally, as public health matters are under the responsibility of various institutions working as part of a complex structure, a strong coordination mechanism is required, with the support and dedication of all stakeholders.

Kosovo

KEY DATA

Total population: in 2017, Kosovo had 1.9 million inhabitants.

High-risk drug use: no estimates of the number of high-risk drug users in Kosovo exist. The most frequently cited estimate of the drug-using population is between 10 000 and 15 000 individuals, and of these between 4 000 and 5 000 are thought to be heroin users (EMCDDA, 2014).

Treatment population: n.a.

Overview of the treatment system in Kosovo

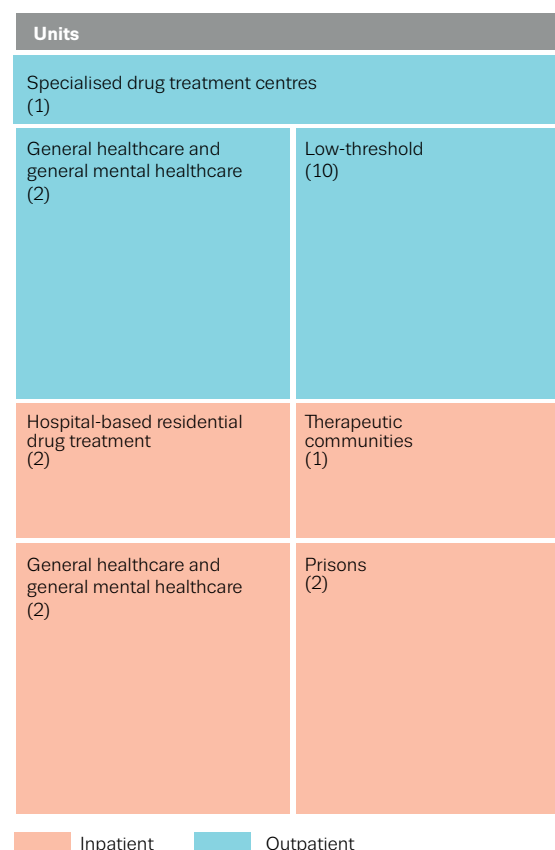
In June 2012, the government approved Kosovo's anti-drug strategy and action plan for 2012-17, with a particular focus on increased cooperation between responsible institutions. The strategy is based on five pillars: demand reduction and harm reduction; supply reduction; cooperation and coordination; support mechanisms; and supervision and monitoring. General goals and specific objectives have been incorporated into these pillars.

Outpatient and inpatient treatment options in Kosovo remain limited, although they are slowly expanding (Figure 8). Two agencies, the Psychiatric Clinic of the University Clinical Centre of Kosovo in Pristina and the NGO Labyrinth, provide most of the drug treatment in the form of detoxification services, psychosocial treatment and OST with methadone. Outpatient psychosocial drug treatment is primarily provided by Labyrinth, which has units in Prizren, Gjiilan and Pristina.

The implementation of methadone maintenance treatment was initiated in April 2012, as part of a Global Fund-supported project at Labyrinth, and it was subsequently introduced in the Psychiatric Clinic of the University Clinical Centre of Kosovo and in regional hospitals in Gjiilan and Gjakova. Two methadone programmes are operating in custodial settings (prisons) in Kosovo. Methadone maintenance treatment is still primarily financed by the Global Fund, and is being expanded in terms of both number of clients and geographical coverage. Primary healthcare providers and public social services are not involved in the treatment of high-risk drug users. This is

FIGURE 8

Total number of units by outpatient and inpatient unit type providing substance-related treatment in Kosovo in 2015



NB: data on the total number of clients by unit type are not available, with the exception of the hospital-based residential treatment unit, which had 60 clients in 2015.

mainly because of a lack of appropriate training and a lack of understanding of these providers' potential role in the field of drug treatment.

Harm reduction programmes were first provided in 2005 by Labyrinth in Pristina. These programmes are now also available in Prizren and Gjiilan, with support from the Global Fund.

There is no data-collection system that covers drug treatment for the entire territory of Kosovo, and the centres involved in treatment provision keep records of their clients separately. The psychiatric clinic provides outpatient and inpatient treatment and represents the main source of information on treatment demand. Data provided by this unit since 2005 indicate a gradual increase in demand for

treatment up to 2009. There were 147 treatment requests in 2005 and 198 in 2009. However, the latest data reported to the EMCDDA indicate that there were 159 requests in 2011.

language checking. There were no particular legal or ethical issues involved.

Results

Findings from the 2017 treatment facility survey using the EFSQ in Kosovo

Sampling

A mapping of institutions to be surveyed was carried out in collaboration with Labyrinth and the Ministry of the Interior, which provided a list of facilities that report twice a year as part of monitoring under the national strategy. The Institute of Public Health also provided a list of public institutions that might provide services to drug users. As a result, the following institutions received an invitation letter and a translated version of the EFSQ: the Psychiatric Clinic of the University Clinical Centre of Kosovo, regional hospitals in the municipalities of Gjiilan and Gjakova, Labyrinth (one specialised outpatient centre in Pristina and two low-threshold centres in Gjiilan and Prizren), the therapeutic community Streha, in Gjiilan, and the Emergency Clinic of the University Clinical Centre of Kosovo. All the facilities but one met the inclusion criterion and participated in the facility survey (Table 5). The emergency clinic was excluded because of a negative response to the inclusion criterion question. Although it was requested that each unit fill out the EFSQ separately, data collection for all the units operated by Labyrinth were processed as one. As a consequence, the data on Labyrinth in this report are aggregate data for all their units.

Kosovo used the translated Albanian version of the EFSQ and sent the survey to Labyrinth for pre-testing and

Type of facilities, geographical distribution and funding

Pristina region

Two units that operate in the capital city, Pristina, took part in the survey. Labyrinth operates a specialised outpatient treatment unit, which also provides OST. The second unit is a hospital-based residential treatment unit, operated with government funding by the Psychiatric clinic of the University Clinical Centre of Kosovo.

Gjiilan and Prizren regions

In the Gjiilan and Prizren regions, four units participated in the survey. A government-funded regional hospital-based inpatient unit, which provides OST, and a low-threshold unit, run by Labyrinth, operate in the Gjiilan region. Additionally, a privately funded inpatient therapeutic community called Streha also operates in that region. A low-threshold unit operates in the Prizren region and is an NGO (a branch of Labyrinth).

Peja and Mitrovica regions

The Peja region has one government-funded regional hospital, which operates an OST programme, whereas the Mitrovica region, based on data from this survey, has no services for

TABLE 5

Number of units by region and unit type in Kosovo in the 2017 EFSQ facility survey

Region	Low-threshold	Outpatient specialised	Outpatient non-specialised	Hospital-based inpatient	Other inpatient	Specialised reintegration/aftercare	Total
Pristina region	0	1	0	1	0	0	2
Gjiilan region	1*	0	0	1	1	0	2 (3*)
Peja region (Municipality of Gjakova)	0	0	0	1	0	0	1
Prizren region	1*	0	0	0	0	0	0 (1*)
Mitrovica region	0	0	0	0	0	0	0
Total	2*	1	0	3	1	0	5 (7*)

NB: data from the two low-threshold units (marked with an asterisk) in Gjiilan and Prizren regions were reported in the responses submitted by the outpatient specialised treatment unit in Pristina. All three units are operated by the same NGO.

drug users. Drug users from Mitrovica seeking support are reported to travel to Pristina to obtain drug services.

The overall geographical distribution of facilities that offer OST is relatively limited. Since 2012, OST has been provided by the Psychiatric Clinic and Labyrinth in Pristina, and by two regional hospitals in Gjilan and Peja. Two big regions, Mitrovica in the northern part of Kosovo and the Prizren region, in the southern part, do not have any services offering OST.

All OST programmes are operating with the financial support of the Global Fund and, for the time being, there is no contingency strategy in case funding is discontinued. In the event of funding disruption, the only option currently available to people undergoing OST is to purchase the methadone themselves in pharmacies with a prescription from a psychiatrist working in a general healthcare unit.

Target population and client characteristics

The findings from the survey revealed that 746 clients were treated for licit and illicit substance-related problems (substance and behavioural addictions) across all treatment units during the 12-month period covered by the survey. The largest proportion of clients was reported by outpatient services (specialised and non-specialised). It should be noted that the number of clients receiving services from the two low-threshold units in the country are included in specialised outpatient treatment since, as indicated above, Labyrinth provided aggregated data for its services. There were 243 people enrolled in OST programmes during that period, one-third of the 746 clients reported in this survey.

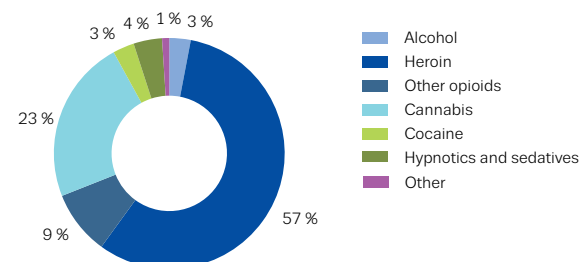
The findings show that the facilities included in the survey provided services primarily to heroin users (57 % of all clients), cannabis users (23 %) and, to a lesser extent, clients with problems associated with the use of opioids other than heroin (Figure 9). The low proportion of individuals with alcohol problems appears to indicate that services addressing alcohol-related dependence operate separately from drug-related services in Kosovo.

Staffing

Staffing remains a challenge for facilities that provide services for addiction-related problems. The survey results indicated that there were 62 paid employees and one unpaid volunteer, representing a total FTE of 41. Medical doctors specialised in psychiatry (10), addiction/psychiatric nurses (8) and general nurses (14) represented approximately half of the total number of paid staff in all

FIGURE 9

Proportion (%) of clients of surveyed facilities by primary substance in Kosovo in 2016 (EFSQ, 2017)



facilities that participated in the survey. The other half included psychologists, social workers, pharmacists, medical doctors not specialised in psychiatry, other health workers without a degree and administrative staff.

Provision of services and quality assurance

Based on data from the respondents, methadone maintenance treatment is provided in four units: one specialised outpatient treatment unit, one hospital-based residential treatment unit and two general mental healthcare units. The results from the facility survey showed that 243 clients were reported to have received OST during the reference period (2016) and seven others were on the waiting list for OST. Pharmacologically assisted management of withdrawal (detoxification) programmes are also provided by all of these units and by the therapeutic community Streha.

Of all the surveyed units in Kosovo, only one, a general mental healthcare unit in Gjakova, responded that it provided services to prisoners in 2016, namely to four prisoners. It should be noted that two methadone programmes operate in prisons in Kosovo, although the units providing these programmes did not take part in the national facility survey.

The availability and provision of harm reduction services, such as street outreach work, distribution of syringes and other drug-injecting equipment or distribution of information material on safer injecting and drug overdose prevention, is limited within the surveyed facilities. Only 20 % to 25 % of surveyed facilities reported that they 'frequently' provide these services, while in most facilities these services were not provided and were reported as not needed. These results may reflect the lack of low-threshold services in the country and the treatment-oriented nature of the facilities taking part in the survey.

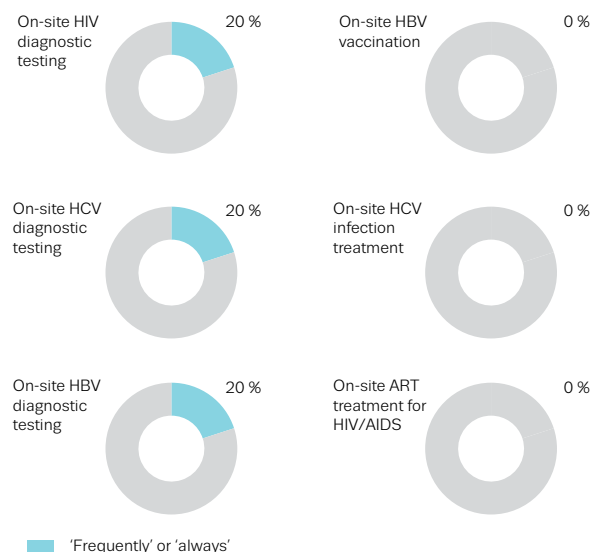
These results are confirmed by the high availability of psychosocial intervention across the surveyed facilities. Individual and group counselling, as well as case management and brief interventions, are the most frequently provided psychosocial interventions (between 60 % and 75 % of units provide these interventions 'frequently' or 'always').

Social reintegration services are rarely offered, with most facilities reporting that they 'never' or 'rarely' provide such services. This may be due to either an overall lack of social reintegration services or the fact that such services are provided by separate social institutions. The latter situation requires efficient partnerships between treatment providers and other service providers to ensure continuity of care and effective housing and employment opportunities. However, while all the surveyed facilities reported established partnerships with health institutions (e.g. hospitals, general practitioners), only the outpatient specialised unit and one of the hospital-based inpatient units reported an established partnership with social services or prison and probation services.

Finally, despite injecting drug users being a high-risk group in regard to the transmission of infectious diseases and the high prevalence of HCV infections among this group in Kosovo (EMCDDA, 2015), only 20 % of surveyed facilities reported frequent or systematic on-site testing for infectious diseases (Figure 10), while provision of treatment or vaccination for these diseases occurs rarely.

FIGURE 10

Proportion (%) of surveyed facilities providing testing for or treatment of infectious diseases 'frequently' or 'always' in Kosovo in 2016 (EFSQ, 2017)



Conclusions and implications

By providing a deeper insight into the reality of treatment facilities in Kosovo, the EFSQ survey shows that a number of core services are well established. However, they are unevenly distributed, leaving significant areas of the country without treatment coverage. The results also show that the current range of available services remains limited. For example, while harm reduction services are now available in three municipalities (all through Labyrinth), they are not provided by other drug treatment units operating elsewhere in the country. Further expansion of core services within a wider national context should, therefore, be prioritised. Despite continued efforts, only a small proportion of the estimated number of people who inject drugs and use opiates such as heroin have access to treatment services. Furthermore, methadone remains the only opioid substitution medication available to people with opiate-use problems. In this regard, enabling a wider range of general healthcare providers to prescribe OST and introducing a larger variety of OST medications, including buprenorphine-based medications, should be considered.

The geographical disparity in the availability of treatment and harm reduction services highlights the need to increase the availability of such services outside the capital. Each region and municipality should allocate some funds to providing various types of services, so that people who inject drugs have easier access to needle and syringe exchange programmes, OST, and HIV, HCV and HBV testing.

Finally, the number of qualified service providers throughout Kosovo, as revealed by this survey, remains small by comparison with the number of people who use or inject drugs. In this respect, funds could be allocated to capacity building and training of existing staff, as well as hiring more qualified professionals, to allow the expansion of services throughout Kosovo.

Serbia

KEY DATA

Total population: as of 1 January 2017, Serbia has 7.05 million inhabitants.

High-risk drug use: for Serbia, data are available only for the estimated number of people who inject drugs, which was approximately 20 500 (95 % confidence interval 16 300 to 27 700) in 2013 (EMCDDA, 2017d).

Treatment population: the latest available data mention that, in 2015, 2 312 individuals received OST in Serbia (EMCDDA, 2017d).

Overview of the treatment system in Serbia

Drug treatment in Serbia falls under the responsibility of the Ministry of Health. The Ministry has established a coordinating and advisory body in the field of drugs: the Republic Expert Commission for the Prevention and Control of Drug Use.

The Law on Psychoactive Controlled Substances, the Law on Health Protection, the Law on Protection of Persons with Mental Disabilities, the Law on the Rights of Patients and the Law on Drugs and Medical Devices regulate the provision of drug treatment. Treatment-related objectives of the Strategy for Drug Abuse Suppression 2014-21 emphasise diversification and the quality of drug treatment by introducing new treatment approaches; promoting treatments that contribute to the reduction of drug-related infectious diseases and drug-induced deaths; expanding access to treatment in prison; and promoting social protection, rehabilitation and reintegration programmes for drug users to minimise social exclusion and discrimination.

Drug treatment in Serbia includes medical detoxification, medication-assisted treatment (with opioid agonists and opioid antagonists), and psychosocial treatments, either as short-term interventions (motivational interviewing, individual psychosocial counselling, individual and group psychotherapy) or long-term rehabilitation group and family therapy. In general, drug treatment is financed through the national Health Insurance Fund.

Drug treatment is provided by state healthcare facilities, and some private health institutions also provide these services. At primary healthcare level, treatment is provided by health centres, and is mostly centred on counselling. Clients are referred to secondary and tertiary healthcare facilities for further treatment. At secondary level, drug treatment is provided by psychiatrists in general hospitals, while specialised drug treatment facilities (tertiary level) are available in Belgrade, Novi Sad, Kragujevac and Niš. These are reference centres for the implementation and supervision of health protection and for developing methodologies for drug prevention, treatment and rehabilitation. Residential treatment is provided in six therapeutic communities (one of them serving women) by the Serbian Orthodox Church, which, in recent years, has served around 200 clients per year. In 2014, the NGO Rainbow provided care and housing to 72 drug users.

Methadone maintenance treatment was first introduced into Serbia at the end of the 1970s, whereas buprenorphine was registered for the treatment of opioid dependence in 2010. Currently, OST is available in all types of health facilities (26 units in 2015) and can be initiated in an inpatient or outpatient healthcare facility; however, the decision to initiate the treatment must be made by a specialised treatment team.

In 2014, 16 of the 26 outpatient treatment units and all three inpatient treatment units provided data on clients entering treatment. A total of 494 clients entered treatment in Serbia in 2014, most of them as outpatients. However, more than half of first-time treatment clients received treatment in inpatient settings (Figure 11).

FIGURE 11
Total number of clients receiving treatment and units providing treatment by outpatient and inpatient unit type in Serbia in 2015



NB: data on the total number of clients from outpatient specialised treatment centres is from 18 units. Data on the total number of clients and units from hospital-based residential treatment and general healthcare and mental healthcare units does not include data from Metohija.

The majority of the clients entered treatment as a result of opioid use. The Serbian TDI currently covers mainly OST services. In 2015, 2 312 persons received OST in Serbia, 1 460 of whom received methadone and 852 of whom received buprenorphine. The available data indicate that the number of OST clients has increased since 2011, when 1 430 OST clients received methadone and 79 received buprenorphine.

Findings from the 2017 treatment facility survey (WHO-UNODC Substance use disorder treatment facility survey)

Sampling

The WHO-UNODC Substance use disorder treatment facility survey questionnaire was used in Serbia with the aim of collecting relevant information on available resources for the treatment of drug use disorders in the country.

The first version of the questionnaire was finalised in June 2015. It was then translated into the local language and submitted to both the Ministry of Health and the Government Commission for the Control of Psychoactive

Controlled Substances for review and comments. The comments related to the terminology that had been used in the instrument, and they provided more information on the cultural adaptation required, suggesting the use of terms that were expected to be clearer for treatment facilities. As agreed with the Ministry of Health, a pilot of an electronic version of the instrument was then carried out online, using a web-based survey platform hosted on a WHO server in Geneva.

Subsequently, between 15 October and 1 December 2017, substance use disorder treatment facilities were contacted by the Ministry of Health. Data were submitted on a specially created web platform hosted on a local server in Serbia. The facilities that did not respond initially were reminded by phone. In total, data were collected from 39 out of the 53 contacted facilities, which corresponds to a response rate of 74 %. Consequently, it is important to note that the results cannot be generalised and are not a sufficient basis for a full assessment of the overall national coverage of substance use treatment in Serbia.

Of the 39 facilities, 20 provided data online, 15 filled in the questionnaire in an electronic format, two sent scans of the completed questionnaire and two replied by post. The results show that not all facilities in Serbia were prepared to participate in an online survey. The reasons for this may include lack of technical equipment, and perhaps insufficient technological literacy.

The data were processed by the UNODC in Belgrade and submitted for further analysis to a national working group, which comprised representatives of the regional clinical centres (departments for substance use disorders) in Belgrade, Novi Sad, Niš and Kragujevac, and representatives of the Ministry of Health.

Ethical concerns

The survey was implemented and coordinated with the Ministry of Health. It was agreed that contact data on facilities providing information would not be published, and that the information on the scope of the services provided to clients in relation to primary substances (Section D), would be available only to the administrators (the Ministry of Health).

Results

Type of facilities, geographical distribution and funding

The data reported in this section were received from 39 facilities/organisations distributed across four regions: Belgrade, Novi Sad, Niš and Kragujevac (Table 6). They included 22 outpatient facilities, 13 hospital facilities and 1 therapeutic facility reporting aggregated data for 4 therapeutic community units belonging to the same NGO. According to the survey results, outpatient units are the most prevalent across the country, followed by inpatient (hospital-based) treatment units. None of the facilities that responded to the survey identified as a low-threshold facility, a specialised social reintegration unit or a unit for non-hospital rehabilitation.

The Belgrade region reported 8 facilities (21 %), Novi Sad and Niš reported 14 facilities each (36 %), and Kragujevac reported 3 facilities (8 %). One therapeutic community from Novi Sad provided data as a central organisation on behalf of four therapeutic community units distributed throughout the country and operated by the same NGO. Regarding the distribution of treatment facilities based on the findings from the facility survey, the Novi Sad region has the greatest variety, including both outpatient and inpatient units and four therapeutic communities, followed by the Niš region, with inpatient and outpatient units, Belgrade and Kragujevac.

TABLE 6

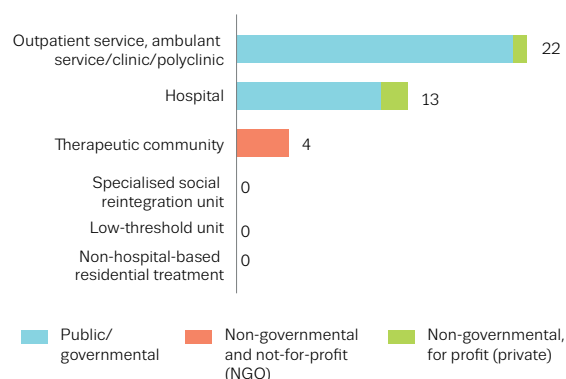
Number of units by region and unit type in Serbia in the 2017 WHO-UNODC facility survey

Region	Low-threshold	Outpatient specialised	Outpatient non-specialised	Hospital-based inpatient	Therapeutic community unit	Other inpatient	Specialised reintegration/aftercare	Total
Belgrade	0	6	0	2	0	0	0	8
Novi Sad	0	4	0	6	4	0	0	14
Kragujevac	0	2	0	1	0	0	0	3
Niš	0	10	0	4	0	0	0	14
Total	0	22	0	13	4	0	0	39

Data from the four therapeutic communities were submitted as one submission in aggregated form by the main parent therapeutic community located in Novi Sad. All four therapeutic communities are operated by the same NGO.

FIGURE 12

Number of surveyed units by affiliation and unit type in Serbia in 2016 (WHO-UNODC facility survey, 2017)



Funding from the government is received by 82 % of the facilities; 10 % are NGOs and non-profit private facilities, which are mainly therapeutic communities connected with religious organisations; and 8 % are for-profit facilities, mostly private clinics (Figure 12). Among the governmental facilities, the Ministry of Health represents the main source of funding, financing 74 % of the facilities (29); the Ministry of Justice funds 10 % (4); and all the other ministries fund 15.5 % (6).

Target population and client characteristics

Depending on the type of facility, there are differences between the primary substances treated. In outpatient

units, clinics and polyclinics, 41 % of clients were receiving treatment for alcohol-related disorders (Figure 13). In hospitals, treatment for problems related to alcohol constitutes 75 % of the services provided; in therapeutic communities, treatment relating to drug use disorders is the most common (68 %). There were no reports on primary treatment for nicotine use disorders.

Overall, 7 629 people with drug use disorders were admitted and treated in 2016 in the facilities that responded to the survey. It should be noted that only 22 facilities out of the 39 that participated in the survey provided data on the total number of treatment clients for the reference period January to December 2016.

Clients who received treatment for problems relating to use of hypnotics and sedatives accounted for the highest proportion of clients in treatment in 2016 (44 %), followed by opioid users, who represented 40 % of clients in treatment (Figure 14). The number of people treated for other drug use disorders was considerably lower. There were 574 clients treated for cannabis use disorders, the majority of whom were treated in hospitals. Stimulant use disorders other than cocaine accounted for 323 clients in 16 facilities. The majority of stimulant clients were treated in clinics, polyclinics and therapeutic communities. According to the facilities that participated in the survey, 55 clients sought treatment for problems relating to the use of hallucinogenic drugs and seven people sought treatment for problems relating to the use of inhalants. For this group, assistance was provided in clinics and polyclinics.

FIGURE 13

Proportion (%) of clients of surveyed facilities by type of unit and type of substance use in Serbia in 2016 (WHO-UNODC facility survey, 2017)

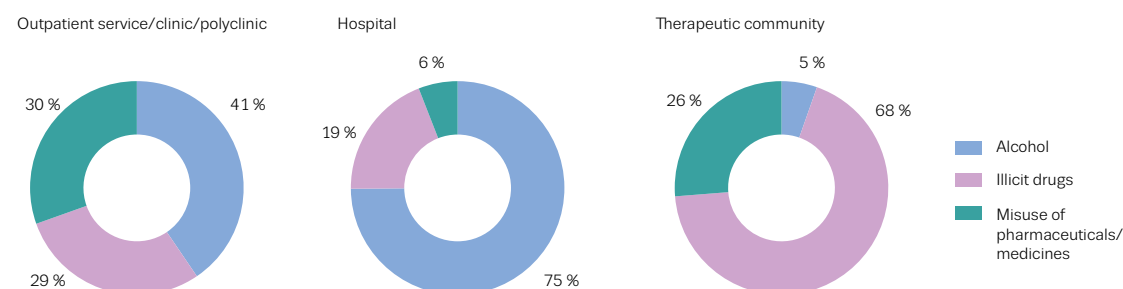
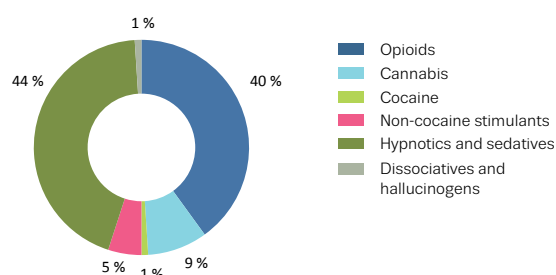


FIGURE 14

Proportion (%) of clients of surveyed facilities by primary substance in Serbia in 2016 (WHO-UNODC facility survey, 2017)



Staffing

In Serbia, 918 people are employed in the treatment of drug and alcohol use disorders, a full time equivalent (FTE) of 706 staff. The number of staff providing non-medical services is 330 FTE in over 15 facilities. A notably small number of field workers, community health workers and pharmacists were reported, which could be due to the lack of low-threshold agencies participating in the survey.

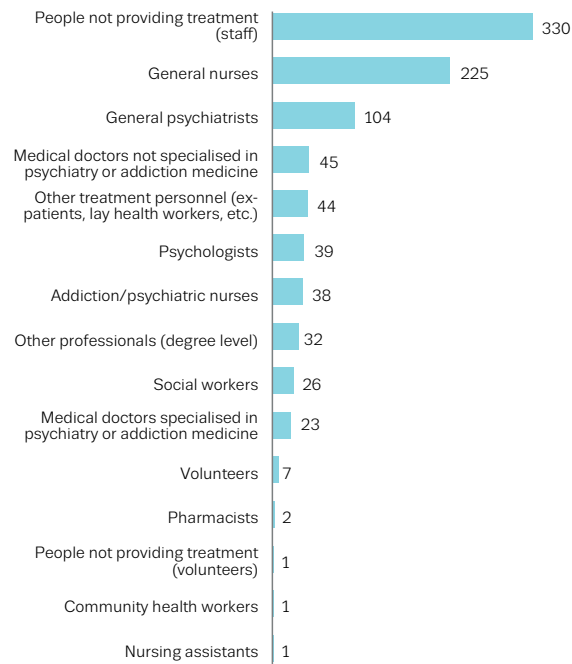
The staff employed in drug treatment facilities are mainly medical specialists, and a small number of facilities report that volunteers work for them. General medicine nurses/ technicians are the most numerous type of staff, followed by general psychiatrists and medical doctors specialised in psychiatry or addiction medicine (Figure 15). There are 104 (69.5 FTE) general psychiatrists in 26 facilities, 23 (15.25 FTE) specialists in addiction medicine in 21 facilities, 39 (20.8 FTE) psychologists in 25 facilities and 225 (146 FTE) psychiatric medical nurses in 26 facilities. The number of social workers is 26 (13.1 FTE) in 21 facilities. Data on the number of volunteers were reported by 17 facilities; there were seven volunteers (all full-time) across all regions.

Provision of services and quality assurance

The findings show that the provision of opioid agonist maintenance treatment for people experiencing opioid-related problems is available in all regions of Serbia. Twenty-six units provided this treatment to 3 247 clients across Serbia during the reference period. There were 273 clients (8.4 %) treated with opioid agonist maintenance treatment in the Belgrade region (6 units); 897 clients treated (28 %) in Novi Sad (6 units); 966 clients treated (31 %) in Kragujevac (2 units); and 1 111 clients treated (34 %) in the Niš region (12 units). Detoxification programmes were found to be available in 34 out of the 39 facilities that participated in the survey.

FIGURE 15

Staffing (FTE) by category of professionals among surveyed facilities in Serbia in 2016 (WHO-UNODC facility survey, 2017)



In terms of psychosocial treatment options, 26 out of 39 facilities, or 67 %, provide brief psychotherapeutic interventions, while extended psychotherapy for longer than two weeks is provided by 74 %. Long-term psychosocial therapy includes approaches such as cognitive behavioural therapy in 10 facilities (26 %), motivational enhancement therapy in 7 facilities (18 %), family counselling in 13 facilities (33 %), individual counselling in 5 facilities (13 %), group counselling in 11 facilities (28 %) and the 12-step facilitation technique in 2 facilities (5 %). Individual counselling is the most common form of psychosocial assistance in outpatient and hospital treatment.

A limited number of facilities reported the availability of specific services for infectious disease testing and treatment and related services; HIV testing is available in 16 out of 39 facilities, or 41 %; HCV testing is available in 15 out of 39 facilities, or 38 %; hepatitis C treatment is available in 7 out of 39 facilities, or 18 %; and antiretroviral treatment is available in 4 out of 39 facilities, or 10 %. HBV testing and treatment was not available in any of the surveyed facilities.

Of the drug treatment facilities in Serbia that responded to the questionnaire, 53 % were accredited (21 institutions), 15 % (six facilities) had not completed the accreditation process, 23 % (nine facilities) were not accredited and three facilities did not provide this information. Of the outpatient treatment facilities, 59 % were accredited; 61 % of the hospital-based facilities were accredited. None of the therapeutic communities was accredited to work with drug users. Of the 21 accreditations issued, 15 had been issued by the Ministry of Health, five by the Ministry of Health Accreditation Agency, and one by the Health Inspectorate of the Ministry of Health. According to the Ministry of Health, the accreditation process is under the authority of the Health Inspectorate; however, accreditation is not a requirement to provide treatment under the currently enforced legislation.

Conclusions and implications

The results of the WHO-UNODC Substance use disorder treatment facility survey highlight the uneven distribution of drug dependence treatment and care services in Serbia, which do not cover all regions of the country. Services are mainly offered in Novi Sad, Niš and Belgrade. For a better understanding of the 2016/2017 WHO-UNODC Substance use disorder treatment facility survey pilot outcomes, it is important to take into account that the data were provided by a limited sample (75 %) of treatment services in Serbia, with some big institutions not participating in the study.

Drug use disorder treatment in principle is available at the primary healthcare level in Serbia, especially

pharmacological treatment of opioid use disorders. Health centres in Serbia offer a variety of services for the treatment of drug use disorders, including medical detoxification, medication-assisted treatment (with opioid agonists and opioid antagonists), short-term psychosocial treatments (e.g. motivational interviewing, individual psychosocial counselling, individual and group psychotherapy) and long-term psychosocial treatments (e.g. rehabilitation group and family therapy). Long-term psychosocial therapy is provided in all hospital facilities but only in 15 outpatient treatment facilities. The limited provision of psychosocial treatment in outpatient clinics and polyclinics might be explained by the excessive workload of the doctors in these services.

The facilities that responded to the survey reported limited availability of HIV, HBV and HCV testing. It should be noted that in Serbia such tests are most commonly administered in public health facilities and infectious diseases wards.

In the future, the quality of care could be improved through targeted capacity building initiatives in the area of drug dependence treatment and care. Additionally, there may be a need for greater standardisation of the conditions and rules for the accreditation of health facilities, as well as a defined body responsible for implementing the accreditation of drug treatment facilities and supervising the accreditation process. It may also be necessary to define who is authorised to accredit facilities outside the health sector, such as therapeutic communities and low-threshold units. These actions would contribute to improving and harmonising the quality of drug use treatment across all sectors dealing with the treatment and care of drug users in Serbia.

Discussion and way forward

This report highlights the complex situation regarding drug treatment systems in the Western Balkan region. Drug treatment systems in the region have common organisational elements, such as general primary healthcare centres, specialised outpatient drug facilities, and inpatient centres at distinct levels, including university medical centres and special psychiatric hospitals. Furthermore, the treatment systems in the Western Balkans are characterised by clear distinctions between publicly funded and owned facilities and NGOs primarily involved in the provision of harm reduction services and OST. Although core specialised and low-threshold services are in place in all four countries, results from the facility surveys have shown that the geographical coverage of available services in the Western Balkan region remains limited, thus confirming previously published data (e.g. EMCDDA, 2015).

Most of the public and non-governmental services are located in major urban centres and densely populated parts of the Western Balkan countries and have little reach outside of these areas. As a consequence, access to treatment for drug users seeking or in need of care is insufficient outside urban areas. To receive care, drug users must migrate or travel to the cities, which is particularly problematic for several reasons. For example, clients living outside cities and requiring daily provision of opioid substitution medication without take-home opportunities may be more likely to skip daily attendance or drop out altogether. Furthermore, services catering for the needs of users in large geographical areas are faced with a high risk of having to operate above their actual capacity, which is particularly true for low-threshold and outpatient services. This challenge is compounded, as the findings from the present surveys make clear, by the fact that the surveyed facilities in all the participating countries lack sufficient qualified personnel.

Expansion and scaling up of drug treatment services nationwide is required in all the countries to provide access to those in need. Actions in this respect might include encouraging the greater involvement of primary healthcare professionals, such as general practitioners and family doctors, outside urban areas. However, primary healthcare providers are not an integral part of national drug treatment systems in the Western Balkan countries, with the exception of Serbia. In addition, increased budgets to permit the hiring of additional qualified staff are needed to address understaffing in existing services in the countries' capitals and large cities.

There is an emerging network of harm reduction services in the region. NGOs and community organisations have played a leading and fundamental role in developing HIV prevention services for people who inject drugs. There is a clear need, however, to scale up the provision of OST and access to syringe exchange programmes, especially beyond capital and larger cities. With evidence of on-going epidemics of hepatitis C, it is also important to strengthen community responses to HCV prevention and treatment, given its potential impact on public health and on national care systems. However, most of these services have until now relied largely on the Global Fund to finance their operations. NGOs surveyed in the facility surveys, both in the territory of Kosovo and in Bosnia and Herzegovina, reported the challenges of achieving sustainability and transitioning to public funding since the Global Fund discontinued its funding of these services in 2016.

In summary, the geographical expansion of services, budgetary consolidation of existing services, quality management of available core interventions and continued investments in improving the monitoring of epidemiological and health response-related data remain priorities and challenges in the region.

However, the results from the treatment facility surveys also highlighted a number of achievements across all the participating countries. Data obtained through this exercise provided new information on the availability of a range of interventions, including specific programmes within existing treatment systems for specific subgroups of drug users seeking support for their drug problems. Thus, needs for the development of services for women and for the homeless drug-using population were identified in some countries.

This first pilot of facility surveys across national treatment systems in the Western Balkan region also contributed to building cooperation between national stakeholders involved in the coordination and monitoring of national treatment systems. Furthermore, it contributed to a revision of existing data on treatment systems and their coverage, as well as of structural and financial information on treatment services. In this respect, the findings can be used to inform the further development of and adjustments to drug policies and strategies.

The results must be viewed with caution, however, since this was the first pilot, created to assess the feasibility of using translated versions of the EMCDDA EFSQ and the WHO-UNODC treatment facility survey. The comparability

of the results between countries is limited because of the differences in design and methodology of the national studies. For example, mainly public institutions were addressed in Serbia, whereas in Albania, Bosnia and Herzegovina and the territory of Kosovo the sampling frame included NGOs. Furthermore, the data from Serbia was collected in 2017 with the WHO-UNODC mapping instrument and a different methodology, which, although compatible with the EFSQ in many ways, may result in differences in the data. Although the response rate in each country was relatively high, not all existing treatment facilities participated in the national surveys. Thus, the current results should not be generalised as they do not provide a sufficient basis for a full assessment of the respective national treatment systems.

Looking to the future, the experience of this first joint EMCDDA-WHO-UNODC exercise in piloting facility surveys among existing structures in national treatment systems

in the Western Balkan region has proven to be successful and provided important new data for national authorities to take into account when planning and commissioning services to meet the needs of high-risk drug users in their countries. As a result, national drug monitoring agencies are encouraged to repeat this exercise on a regular basis while continuing their efforts to implement robust treatment client monitoring systems across their national treatment systems. These two data collection exercises should be viewed as complementary parts of an overall effort to provide the comprehensive information and evidence necessary for informed and sound decision-making.

In this respect, it is important that national drug monitoring agencies provide support and incentives to the treatment centres participating in these surveys and react in a flexible way on the wider implementation of such data collection exercises.

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About this publication

This report presents a summary of the key findings from drug treatment facility surveys carried out in 2017 in Albania, Bosnia and Herzegovina, Serbia and the territory of Kosovo. The results provide insight into the characteristics and capacity of the treatment systems, as well as the availability and provision of treatment interventions. The report also considers the implications for practice and policy.

About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

About UNODC

UNODC, the United Nations Office on Drugs and Crime, is the United Nations Secretariat entity responsible for supporting Member States in their efforts to address drugs and crime. UNODC's work on prevention and treatment of drug use disorders includes also the support for the development of drug information systems to support the planning of adequate prevention and treatment services. Established in 1997 through a merger between the United Nations Drug Control Programme and the Centre for International Crime Prevention, UNODC operates in all regions of the world through an extensive network of field offices and provides technical assistance to UN Member States.

